

# SOWN News

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## CMS Announces Payment Reforms for Inpatient Hospital Services in 2008

*Reforms Continue Transition to More Accurate Payment System, Promote Quality Care for All Hospitalized Patients*

The Centers for Medicare & Medicaid Services (CMS) issued a final rule on August 1 that takes significant steps to improve the accuracy of Medicare’s payment under the acute care hospital inpatient prospective payment system (IPPS), while providing additional incentives for hospitals to engage in quality improvement efforts.

“The IPPS payment reforms we are making today finalize the changes we proposed in April and build upon three years of consistent, incremental improvements to Medicare inpatient hospital payments,” CMS Acting Deputy Administrator Herb Kuhn said. “With these changes—

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### Abstraction Guidelines to Change

October 1, 2007, marks the beginning of the use of Version 2.3 of the *Specifications Manual for National Hospital Quality Measures (Specifications Manual)*. This manual will affect the abstraction of medical records of patients discharged October 1, 2007, through March 31, 2008. To access the manual, go to <http://www.qualitynet.org/dcs/ContentServer?cid=1141662756099&pagename=QnetPublic%2FPage%2FQnetTier2&c=Page>. To assist you, changes to this version of the manual have been highlighted.

Please ensure that abstractors are familiar with the changes in the definitions of the data elements with the release of this manual. A comprehensive list of all of the changes is included in the *Specification Manual*, posted as “Release Notes.”

PN changes include, but are not limited to:

1. PN-5—Timing
  - PN-5a is retired
  - PN-5c is no longer a “test measure”

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first proposed by the Medicare Payment Advisory Commission in 2005—Medicare payments for inpatient services will be more accurate and better reflect the severity of the patient’s condition.”

“Moreover, combined with payment system rules we released this week on inpatient rehabilitation facilities and skilled nursing facilities, we are demonstrating our commitment to ensure that the Medicare program is sustained for future generations by paying accurately and efficiently,” added Kuhn.

### *IPPS Payment Reforms*

The IPPS payment reforms would restructure the inpatient diagnosis-related groups (DRGs) to account more fully for the severity of each patient’s condition. In addition, the rule includes important provisions to ensure that Medicare no longer pays for the additional costs of certain preventable conditions (including certain infections) acquired in the hospital. The rule also expands the list of publicly reported quality measures and reduces Medicare’s payment when a hospital replaces a device that is supplied to the hospital at no or reduced cost.

Payments to all hospitals will increase by an estimated average of 3.5 percent for FY 2008 when all provisions of the rule are taken into account, primarily as a result of the 3.3 percent market-basket increase. Payments to specific hospitals may increase more or less than this amount depending on the patients they serve. For instance, urban hospitals generally treat more severely ill patients and are estimated to receive a 3.8 percent increase in payments.

“The good news is that hospitals across the nation, the District of Columbia, and Puerto Rico will see their payments increase under this final rule by nearly \$4 billion. This three-year effort to reform Medicare’s hospital payment system will ensure predictability, reliability, and fairness of Medicare payments well into the future,” said Kuhn.

### *MS-DRGs*

In the previous two years, Medicare made important, incremental changes while it studied comprehensive reform of the inpatient hospital payment system. This year, the rule creates 745 new severity-adjusted

diagnosis-related groups (Medicare Severity DRGs, or MS-DRGs) to replace the current 538 DRGs. Projected aggregate spending will not change as a result of the reforms. However, payments will increase for hospitals serving more severely ill patients and decrease for those serving patients who are less severely ill.

The changes Medicare is adopting are consistent with public comments on how the reforms should occur and were widely praised in the public comments. Based on these public comments, the new severity-adjusted DRGs will be phased in over two years, rather than one year, as detailed in April’s proposed rule. In addition, important first steps are taken in response to an extensive study of “charge compression.” CMS is making some initial changes this year and is further studying how to better recognize the cost of expensive devices as it considers other improvements to its payments for FY 2009.

The Medicare Actuary estimates that without an adjustment to account for changes in how hospitals document and code patient severity of illness, the new system would increase payments.

“In keeping with the law, the new basis for DRGs is not intended to reduce overall Medicare costs or to increase them. Based on more than 20 years of program experience with such changes, a documentation and coding adjustment is needed to make sure the new system is budget neutral,” said CMS Chief Actuary Richard Foster. “Substantial evidence supports our conclusion that, absent such an adjustment, aggregate payments for inpatient hospital services would increase significantly under the new system—without any corresponding growth in actual patient severity. If we didn’t make this adjustment, the Medicare Part-A Trust Fund would be exhausted an estimated 18 months earlier than previously forecast.”

The changes reflect recommendations from the Medicare Payment Advisory Commission (MedPAC). CMS took its initial steps toward implementing the new system when it created new DRGs for cardiac procedures performed in FY 2006. An additional set of DRGs reflecting severity of illness was introduced for more procedures in FY 2007.

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By more accurately recognizing the costs of caring for a patient, the new MS-DRGs should help reduce the potential for abusive practices. Under the old DRG system (with payments based on broad averages) incentives could lead hospitals to “cherry pick”—the practice of treating only the healthiest and most profitable patients.

The new MS-DRGs help address the concerns that certain specialty hospitals—hospitals that provide a limited range of services and typically are owned in whole or in significant part by physicians who serve as referral sources—may selectively provide such profitable services. Finally, by paying more accurately for inpatient services, MS-DRGs will minimize the cost shifting hospitals now say they have to make to account for variation in payment among Medicare inpatient procedures.

In addition to the base payment for the DRGs, the law requires Medicare to make a supplemental payment to a hospital if its costs for treating a particular case exceed the usual Medicare payment for that case by a set threshold. Medicare sets the threshold for high-cost cases at an amount that is projected to make total “outlier payments” equal to 5.1 percent of total inpatient payments. For FY 2008, CMS is adopting a high-cost outlier threshold of \$22,650, down from \$24,485 in FY 2007.

By better recognizing severity of illness in the DRG reforms that are part of this final rule, fewer cases would be paid as outliers if CMS did not reduce the fixed-loss amount. Reducing the fixed-loss amount will help assure that hospitals that do treat these extremely costly cases will have an easier time qualifying for outlier payments.

### ***Capital-Related Costs***

The rule also changes the way Medicare pays for hospital capital-related costs based on an analysis that showed substantial positive margins experienced by some hospitals. In response to comments from MedPAC and other parties, the rule does not finalize the proposal to provide a zero payment update for urban hospitals and instead provides a full update for all hospitals. However, the final rule does eliminate the large urban add-on payment and adopts a policy of discontinuing the teaching adjustments to capital pay-

ments over a three-year period.

### ***No Payment for Hospital-Acquired Conditions***

The rule implements a provision of the Deficit Reduction Act of 2005 (DRA) that takes the first steps toward preventing Medicare from giving hospitals higher payment for the additional costs of treating a patient who acquires a condition (including an infection) during a hospital stay.

Already the feature of many state health care programs, the DRA requires hospitals to begin reporting secondary diagnoses that are present on the admission of patients, beginning with discharges on or after October 1, 2007. Beginning in FY 2009, cases with these conditions would not be paid at a higher rate unless they were present on admission.

In order to improve the reliability of care in the nation’s hospitals, the rule identifies eight conditions, including three serious preventable events (sometimes called “never events”) that meet the statutory criteria. CMS will work to add an additional three conditions to the list next year.

### ***30-Day Mortality and Surgical Care Measures***

The final rule adds new quality measures that hospitals would need to report in calendar year (CY) 2008 in order to qualify for the full market-basket update in FY 2009.

CMS will measure 30-day mortality for Medicare patients with pneumonia and plans to adopt two measures relating to surgical care improvement in the CY 2008 outpatient prospective payment system final rule. In addition, CMS will finalize two additional surgical care improvement measures by program notice after they receive NQF endorsement.

The provision of the law specifies that Medicare payments for inpatient hospital services be adjusted if hospitals fail to report this quality information. Hospitals that report quality information will receive the full market-basket update. For those that do not report, the market-basket update will be reduced by 2.0 percentage points.

“Taken together, these two initiatives will significantly improve the quality and reliability of care delivered

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in the nation's hospitals," said Kuhn. "These reforms not only represent CMS' continued push to create more transparency in our health care system, they also put us on more secure footing as we strive to become a more active purchaser of high quality care for Medicare beneficiaries."

### *Payment for Medical Devices*

CMS will also change the way it pays for medical devices that are recalled or replaced at no or reduced cost to the hospital. The policy is consistent with the policy CMS adopted for outpatient payments beginning January 1, 2007. Under the IPPS, payment for these devices is included in the payment for the DRG. Currently, Medicare pays the same for the second procedure even if the hospital acquires the device for free or at reduced cost, as it did for the initial procedure when the hospital had to purchase the device. The rule reduces payment when hospitals use a recalled or replacement device at no cost or with partial credit.

### *Specialty Hospitals*

In keeping with the plan contained in CMS' August 2006 final Report to Congress on specialty hospitals, the rule creates new disclosure requirements for these hospitals. The rule requires physician-owned hospitals to disclose such ownership to patients and provide the names of the physician owners upon request.

The rule also requires physician-owned hospitals to require physician owners who are members of the hospital's medical staff to disclose their ownership to the patients they refer to the hospital. Disclosure would be required at the time of referral.

In addition, the rule requires a hospital to notify all patients in writing if a doctor of medicine or doctor of osteopathy is not present in the hospital 24 hours a day, seven days per week, and describe how the hospital will meet the medical needs of a patient who develops an emergency condition while no doctor is on site. CMS now has the authority to terminate a provider agreement for noncompliance with these disclosure requirements.

### *Aligning Payment With Costs of Care*

The rule continues to phase in a change introduced

in FY 2007 that would better align payment with the costs of care by using estimated hospital costs, rather than list charges, to establish relative weights for the DRGs. Under the rule, hospitals will be paid during 2008 based on a blend of one-third charge-based weights and two-thirds hospital cost-based weights for the DRGs. In 2009, hospitals will be paid 100 percent based on cost-based DRG weights.

To read more on this rule, please click this URL for the IPPS regulation: <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-FC.pdf>

### **CMS Announces Start of Participant Recruitment for Post-Acute-Care Payment Reform Demonstration**

The Centers for Medicare & Medicaid Services (CMS) has announced the start of participant recruitment for the Post-Acute-Care Payment Reform Demonstration (PAC-PRD). Participating providers include acute care hospitals and four post-acute care (PAC) settings—long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and home health agencies (HHAs).

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### **Medicare Provider Information**

To view HSAG's new Medicare Provider Web page that contains information about fee-for-service and Medicare Advantage benefits, visit <http://www.hsag.com/providers>.

The page contains information on:

- The beneficiary notices initiative (BNI).
- Managed care appeals and grievances.
- Sample notice forms (downloadable).
- The *Federal Register* BIPA regulation.

### **Medicare Beneficiary Rights**

All Medicare beneficiaries have the right to appeal their discharge from a hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility. For more information, go to <http://www.hsag.com/azmedicare> or call 1.800.359.9909.

A key goal of this project is to generate recommendations for improving CMS payment models based on data collected in the demonstration. The goals of payment reform include aligning incentives among the four PAC settings with a particular focus on patient populations seen in more than one PAC setting. Other analyses to be explored include the examination of discharge patterns and the comparison of outcomes between settings.

### *Continuity Assessment Record and Evaluation*

An important part of PAC-PRD is improving CMS' ability to understand and compare the populations served in acute hospitals and each of the four PAC settings and the care that is received. Work has been underway for the past year to develop a uniform patient assessment tool for use at discharge from acute hospitals and at admit and discharge from PAC settings. This patient assessment tool is known as CARE: Continuity Assessment Record and Evaluation.

In addition to the CARE instrument, the demonstration has developed methods for measuring the costs and resource use associated with individual patients. The next step will be to implement the demonstration by collecting information from participating providers.

### *Provider Recruitment*

At this point, CMS is attempting to recruit providers to participate in this data collection effort. Participation is voluntary. CMS does not envision exercising any waivers of payment rules for this project. CMS will attempt to recruit a sample that is representative of the range of post-acute service providers across the country.

CMS will collect data in 10 distinct parts of the country. The choice of which 10 markets to select will be influenced by a variety of factors, including population density, geographic area, the presence of different types of PAC providers, and whether there are volunteer providers available. The selection of which providers to include in a given market will depend on characteristics such as patterns of corporate ownership, profit status and size of individual providers, the ability to recruit other providers in the same referral network, and the need to recruit a representative sample.

This demonstration will give CMS and Medicare-participating providers better information on the case-mix

severity of Medicare beneficiaries using their services. The information will be critical in creating recommendations for refining CMS approaches to measuring case mix intensity in PAC populations. Adopting techniques that provide greater uniformity in how patients are assessed and quality is measured will allow CMS to improve PAC payments.

### *Provider Participation*

The Post-Acute-Care Payment Reform Demonstration was mandated by Congress in the Deficit Reduction Act of 2005. Recommendations generated by the demonstration will be included in a report to Congress that is also mandated as part of the same law. Providers may express interest in participating. In addition, providers may also be targeted for recruitment from analysis of Medicare administrative files and will be contacted. Final selection of the provider participants will occur in the fall of 2007. Providers interested in potentially participating in the 2008 demonstration should contact Barbara Gage, PhD, Principal Investigator at RTI, by e-mailing [PAT-COMMENTS@RTI.org](mailto:PAT-COMMENTS@RTI.org).

## One Arizona Hospital Achieves Perfect Validation Score for Medical Record Abstraction

**Northwest Medical Center** in Tucson achieved a 100 percent agreement rate on its CMS validation score for the most recently finalized validation quarter, the third quarter of 2006.

Currently, the threshold for passing CMS validation is an agreement rate of 80 percent. The vast majority of Arizona hospital abstraction results meet this standard. Indeed, many hospital scores are above 90 percent agreement each quarter. However, it is still rare for a hospital to achieve 100 percent agreement with CMS in its re-abstraction process. This is an indication of dedicated abstractors who are well trained, knowledgeable of the criteria and the changes in criteria, and who routinely use the CMS/Joint Commission specifications manual.

As a tribute to the abstractors—and the administration that places a priority on their work—HSAG is honored to congratulate **Northwest Medical Center** for achieving a 100 percent CMS validation score.

## IHI Innovation Series White Paper

### *Execution of Strategic Improvement Initiatives to Produce System-Level Results*

Quality and safety occupy a prominent place in the strategic plans of many health care organizations. However, a common organizational response to this emphasis on quality and safety is a long list of worthwhile projects and measures that are not well coordinated, let alone capable of achieving system-level results.

The Institute for Healthcare Improvement (IHI) uses a simple mantra to describe the essential elements for strategic improvement: Will, Ideas, and Execution. You have to have the will to improve, you have to have ideas about alternatives to the status quo, and then you have to make it real—execution.

Achieving results at the system or organizational level requires will at all levels, but especially the will of top management to make a new way of working attractive and the status quo uncomfortable. The new system will require new ideas about how work gets done, how relationships are built, and how patients participate in their care. Processes to scan widely within and outside of health care will be needed to find ideas robust enough to form the basis of a new system that performs at unprecedented levels. No single initiative or set of unaligned projects will likely be enough to produce system-level results.

This paper proposes a framework for execution of strategic initiatives aimed at producing system-level results. To download a PDF file of this paper, go to <http://www.ihl.org/IHI/Results/WhitePapers/Execution-ofStrategicImprovementInitiativesWhitePaper.htm>.

## Reducing Harm From MRSA

The Institute for Healthcare Improvement (IHI) estimates that nearly 15 million instances of medical harm occur annually in the United States, equaling a rate of 40,000 incidents per day. Health care professionals are intimately acquainted with these incidents, and for the most part believe they're unavoidable circumstances. Of the six new targeted interventions in the *5 Million Lives Campaign*, reducing methicillin-resistant *Staphylococcus aureus* (MRSA) hospital-wide infections fits

right into that old way of thinking. Seventy percent of hospital-acquired infections are due to bacteria that are resistant to previously effective antibiotics, with MRSA being one of the fastest growing and most virulent offenders. The Centers for Disease Control and Prevention (CDC) attributes more than 50 percent of hospital-acquired *S. aureus* infections—63 percent in ICUs—to MRSA. The CDC estimates that over 126,000 hospitalized patients are infected with MRSA annually, leading to approximately 5,000 deaths. Hospitalized MRSA patients have an increased length of stay up to 9.1 days, with roughly \$30,000 in additional costs per episode.

To read more about best-practice protocols for MRSA, visit: [http://www.nursingcenter.com/library/JournalArticle.asp?Article\\_ID=735642](http://www.nursingcenter.com/library/JournalArticle.asp?Article_ID=735642).

The Arizona Hospital and Healthcare Association is currently developing the strategies and tactics for a statewide initiative that will address MRSA. Updates and notices will be provided as it gets closer to the launch of the initiative. For information, contact Barb Averyt at [baveryt@azhha.org](mailto:baveryt@azhha.org) or 602.445.4300.

## *Boston Globe* Offers Patients Advice About Infections

To read about how one newspaper, *The Boston Globe*, is encouraging patients to be proactive in the fight against hospital-acquired infections, go to [http://www.boston.com/yourlife/health/diseases/articles/2007/08/27/patient\\_protect\\_thyself/](http://www.boston.com/yourlife/health/diseases/articles/2007/08/27/patient_protect_thyself/).

## CMS Guidance on Tamper-Resistant Prescription Pads

The Centers for Medicare & Medicaid Services (CMS) recently sent a letter to State Medicaid Directors offering guidance on the use of tamper resistant prescription pads. Section 7002(b) of the “U.S. Troop Readiness, Veterans’ Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007” requires that a tamper-resistant prescription pad be used for all written, non-electronic prescriptions for Medicaid outpatient drugs in order for them to be reimbursable by the federal government. The recent letter gives baseline requirements to states so they can implement requirements for use by the October 1, 2007, deadline.

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By the October 2007 deadline, states must require all Medicaid prescriptions to meet at least one of the following three characteristics:

1. Prevent unauthorized copying of a completed or blank prescription form;
2. Prevent the erasure or modification of information written on the prescription by the prescriber; or
3. Prevent the use of counterfeit prescription forms.

By October 1, 2008, states must require that all three conditions be met in order for a prescription pad to be considered tamper-resistant and the prescription reimbursable by federal funds.

The state Medicaid director letter is available at <http://www.cms.hhs.gov/SMDL/downloads/SMD081707.pdf>. A policy backgrounder for state policymakers is available at <http://www.cms.hhs.gov/DeficitReductionAct/Downloads/Tamper.pdf>.

### New Report Looks at Health IT and Quality of Care

A compelling new report from the Agency for Healthcare Research and Quality, co-authored by IHI's Carol Beasley and Jerry Langley, examines the link between health information technology (IT) and quality improvement in a range of primary care settings. The bottom line is that, while new systems show promise, health IT adoption must go hand-in-hand with a robust care model and routine use of quality improvement methods. To read the report, go to [http://healthit.ahrq.gov/portal/server.pt/gateway/PTARGS\\_0\\_1248\\_661809\\_0\\_0\\_18/AHRQ\\_HIT\\_Priary\\_Care\\_July07.pdf](http://healthit.ahrq.gov/portal/server.pt/gateway/PTARGS_0_1248_661809_0_0_18/AHRQ_HIT_Priary_Care_July07.pdf).

### IHI Update

Enrollment scholarships are available in cases of financial hardship for those wishing to attend IHI programs. Those interested in applying should visit the [IHI Web site](#), complete the appropriate application, and submit it via e-mail to [info@ihi.org](mailto:info@ihi.org).

Cardinal Health's patient safety grants are available to those hospitals and health systems already enrolled in the IHI's *5 Million Lives Campaign*. The competitive \$1 million grant program provides up to \$50,000 in

funding to each grantee for new programs that establish or implement creative and innovative methods for addressing challenges in providing quality patient care. More information is available at <http://www.cardinal.com/us/en/aboutus/community/opportunities/patientsafety/index.asp>.

The most high-performing *Campaign* participants regularly use the many free resources provided by IHI on the *Campaign* Web site, <http://www.ihi.org/IHI/Programs/Campaign/>.

New tools for Rapid Response Teams are available. Look for the "New" label in the Rapid Response Team tools area of the Materials tab, <http://www.ihi.org/IHI/Programs/Campaign/Campaign.htm?TabId=2#DeployRapidResponseTeams>.

**IMPORTANT:** Please note the new call-in information for all *Campaign* conference calls!

Dial 800.860.2442; no PIN code is required. Please ask the operator to connect you to the appropriate call.

Upcoming *Campaign* live calls:

- Preventing Harm from High-Alert Medications  
Tuesday, September 11, 2007  
2–3 p.m. Eastern
- Deploying Rapid Response Teams  
Thursday, September 13, 2007  
1–2 p.m. Eastern
- Reducing MRSA  
Tuesday, September 18, 2007  
3–4 p.m. Eastern
- Improving CHF Care  
Thursday, September 20, 2007  
1–2 p.m. Eastern
- Boards on Board  
Tuesday, October 2, 2007  
4–5 p.m. Eastern
- Preventing Pressure Ulcers  
Thursday, October 4, 2007  
1–2 p.m. Eastern
- Preventing Adverse Drug Events (Medication Reconciliation)  
Tuesday, October 9, 2007  
1–2 p.m. Eastern

- Preventing Surgical Complications  
Thursday, October 11, 2007  
2–3 p.m. Eastern

## Varenicline (Chantix): New Addition to State-Sponsored Benefit for Tobacco Cessation

FDA-approved cessation medications can double or even triple a patient's chances of successful abstinence from tobacco. That is why the U.S. Public Health Service Clinical Practice Guideline recommends that all people trying to quit tobacco be encouraged to use effective cessation medications, unless they present with special circumstances. The Arizona Department of Health Services Tobacco Education and Prevention Program increases access to medication by offering six weeks of free or reduced-cost cessation medication to individuals enrolled in State-sponsored cessation classes and/or telephone counseling.

As of July 1, 2007, the prescription medication varenicline (Chantix) is a new addition to the state-sponsored benefit. Varenicline (FDA-approved in May 2006) is a non-nicotine replacement therapy that works by binding to nicotine receptors in the brain. This binding action helps patients in two ways: by easing nicotine withdrawal symptoms and by blocking the effects of nicotine if individuals resume smoking. Patients taking varenicline for tobacco cessation will not experience the same pleasurable effects of nicotine if they slip or relapse during treatment, which may help them to sustain a quit attempt.

To be considered for the state-sponsored medication benefit—which now includes varenicline (available in a single 4-week supply due to packaging considerations), bupropion SR, and the nicotine patch, gum, and lozenge—individuals must participate in telephone counseling through the Arizona Smoker's Helpline (1.800.55.66.222 or [www.ashline.org](http://www.ashline.org)) or be enrolled in state-sponsored cessation programs. To find state-sponsored programs in your area, visit the Arizona Department of Health Services Tobacco Education and Prevention Program's Web site at [www.betobaccofree.org](http://www.betobaccofree.org).

### Earn CEU/CME—Accredited Certification

With tobacco dependence treatment certification, you can deliver a lifesaving message in as little as

three minutes. The University of Arizona HealthCare Partnership offers free evidence-based continuing education programs in locations throughout Arizona. The workshops, including Brief Tobacco Intervention Skills and Medical and Allied Health Professionals Basic Skills, offer CEU/CME and are funded by the Arizona Department of Health Services Tobacco Education and Prevention Program.

To see a calendar of events or to register for certification workshops, visit [www.healthcarepartnership.org](http://www.healthcarepartnership.org). To coordinate a Tobacco Dependence Treatment Continuing Education Program at your facility, contact Renee Sayre, HealthCare Partnership Program Coordinator, at 520.318.7253, ext. 170, or send a request to [hcpinfo@u.arizona.edu](mailto:hcpinfo@u.arizona.edu).

## New Medicare Rules Proposed for Ambulatory Surgery Centers

The Centers for Medicare & Medicaid Services (CMS) has issued a proposed rule that will revise the requirements that ambulatory surgical centers (ASCs) must meet in order to bill Medicare for services furnished to beneficiaries.

This proposed rule would update the existing ASC Conditions for Coverage (CfC) to reflect contemporary standards of practice in the ASC community, as well as recommendations from the HHS Inspector General. The new requirements will promote and protect patient access to quality services in ASCs.

ASCs are typically free-standing facilities that perform outpatient surgery. To participate in the Medicare program, they must meet Medicare's conditions for coverage.

The most commonly performed ASC procedures currently include cataract removal and lens replacement, other eye procedures, and colonoscopy. However, the specific types of procedures that will be covered when performed in an ASC, and the payment rates that will apply, have been dramatically changed as a result of a final ASC payment methodology rule that was issued by CMS on July 16, 2007.

That final rule is intended among other things, to provide ASC payment for additional surgical procedures

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and create a rational relationship between payments for services furnished in ASCs and the same services when performed in either a hospital outpatient department or a physician's office. As a result of the added procedures to be paid in ASCs and the revised ASC payment rates for existing ASC services, there may be a significant change in the mix of services performed in ASCs and in the alternate settings.

CMS expects that some of the new ASC procedures currently performed in the hospital outpatient department and the physician's office will move to the ASC setting, and that there will also be migration of existing ASC procedures both into and out of ASCs as a result of the revised ASC payment system.

On July 16, 2007, CMS also issued a proposed rule setting payment rates and adding procedures to the ASC-covered list, effective for ASC services performed on or after January 1, 2008. The comment period on the proposed payment rates rule closes on September 14, and a final rule will be issued on or before November 1, 2007.

The proposed rule changes include:

- A more comprehensive quality assessment and performance improvement condition (QAPI) that enables ASCs to take tailored proactive steps to ensure quality care.
- Requiring the ASC's governing body to be responsible for the oversight and accountability for the updated QAPI program.
- Adding a new disaster preparedness plan standard to address emergency preparedness within the facility and interaction with local and state officials.
- Adding requirements for radiologic services provided in an ASC to ensure they are parallel to the requirements for furnishing laboratory services.
- Adding a new patient rights condition to address disclosure of physician financial interests in the ASC, advance directives, the grievance process and confidentiality of clinical records.
- Expanding the infection control requirement to the condition level.
- Adding a comprehensive patient assessment requirement to ensure that accurate and thorough

assessments are conducted to assure appropriate and safe surgery, and that patients would be able to tolerate a scheduled surgical procedure.

The proposed rule is on display at the Office of the *Federal Register* and is posted on the CMS Web site at <http://www.cms.hhs.gov/CFCsAndCoPs/Downloads/amburgreg.pdf>.

Information about the final payment methodology rule and the proposed payment rule for calendar year 2008 can be found at the same link. Public comments will be accepted until October 30, 2007, and a final rule will be issued later this year.

### Abstraction Guidelines to Change

*(Continued from page 1)*

2. Pneumonia Population
  - ICD-9-CM Codes 482.81 and 487.0 have been removed from the population
3. PN-7 Influenza Vaccination—The flu season has been extended to include March [*Note: This would be a good time to change standing orders to include March.*]
4. Clinical Trial—Now collected for ALL measures
5. Antibiotic Selection Changes
  - Non-ICU, ICU and *Pseudomonal* risk
  - Remove Gatifloxacin as a recommended Antipneumococcal Quinolone
  - ICU with Beta-Lactam allergy: Antipneumococcal Quinolone—Clindamycin is no longer an option
  - ICU New option with Beta-Lactamallergy: Antipneumococcal Quinolone + Aztreonam
  - ICU: Remove Ertapenem as a recommended Beta-Lactam
  - *Pseudomonal* risk with Beta-Lactamallergy: Aztreonam + Levofloxacin
6. Adult Smoking—There have been significant changes made to shorten and simplify abstraction guidelines in an effort to make abstraction quicker and easier.

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7. Another Suspected Source of Infection—Changed from “upon admission” to “within 24 hours of arrival” and Appendix A, Table 5.09, has been removed.
  8. Antibiotic Administration, Date, Route, Name and Received—All antibiotic information for a single antibiotic must come from a single source. Also, either a signature or initials must accompany any antibiotic abstracted.
  9. Blood Culture Collection After Arrival—Now only looking at BC collected within 36 hours of arrival. Also, for the purposes of this measure, a patient is no longer considered an ED patient after the admission order is written, regardless of location.
  10. Chest X-Ray—“Old” is no longer used for the data element and there is now a list of Exclusions to help ascertain findings that should not result in a “yes.”
  11. Comfort Measures Only—You will no longer be trying to ascertain if CMO was received during the hospitalization. The data element has changed such that the abstractor no longer has to try to make a judgment call.
  12. Compromised—New easier to read format. Also, clarification that only systemic corticosteroids are to be collected.
  13. Health Care Associated PN—Wound care documented without a time frame to indicate it was within the last 30 days will not be acceptable
  14. Influenza Vaccination Status—Value 6 has changed to cover distribution and production problems. There are also new instructions regarding what to do if multiple allowable values are appropriate.
  15. Initial Blood Culture Collection Time and Date—Only including blood cultures collected within 36 hours of arrival. Also, there is now a note instructing the abstractor to collect a time and date if there is documentation a blood draw was attempted but unsuccessful.
  16. Pneumococcal Vaccination Status—There are new instructions regarding what to do if multiple allowable values are appropriate.
  17. Pneumonia Diagnosis: ED/Direct Admit—New allowable value, “UTD”; if chosen, the case will fail for all admission measures.
  18. Risk Factors for Drug-Resistant Pneumococcus—This data element no longer looks at “any chronic systemic illness.” Medical co-morbidities are now defined a Note for Abstraction.
- Surgical Care**
- SCIP changes include, but are not limited to:
1. INF-1
    - Patients who had a hysterectomy and caesarean section performed during the same hospitalization will be excluded from the denominator.
  2. INF-2
    - Ertapenem is now acceptable for colon surgeries (Table 5.03).
    - Colon surgeries that receive only oral antibiotics will no longer pass INF –2.
  3. CARD-2
    - Pregnant patients will be excluded from the denominator.
  4. INF-1,2,3
    - All elements of antibiotic administration must be included, name, route, time; if the information is not present, utilize UTD.
  5. VTE
    - Documentation of active bleeding is now acceptable.
    - The time frame has been changed. The abstractor only collects VTE prophylaxis ordered from hospital arrival to 48 hours after surgery.
  6. Infection Prior to Anesthesia
    - “Acute abdomen” has been added to the inclusion list.
  7. Laparoscope
    - Procedures labeled as “hand-assisted,” “laparoscopically-assisted,” or those performed with a “hand-port” are not considered totally laparoscopic.

*(Continued on page11)*

### 8. Preadmission Warfarin

- The intent of this data element is to exclude patients on continuous warfarin therapy prior to hospitalization. To be excluded with the data element Preadmission Warfarin, the patient should be on continuous therapy prior to admission. If the warfarin was placed on hold greater than seven days prior to surgery, the abstractor should answer “no.”

### 9. INF-7

- The time frame for collecting the postoperative temperature was changed from one hour to 15 minutes.

### AMI and HF

AMI and HF changes include, but are not limited to:

1. Patients involved in a clinical trial relevant to AMI will be excluded.
2. AMI-7,8
  - “Cardiopulmonary arrest” was added to the list of examples noted in the denominator exclusion statement.
3. Adult Smoking History
  - Source list limited to three “Only Acceptable Sources”: ED record, H&P, and nursing admission note.

- Abstractors only need to look through the three designated sources for smoking history information. Information in any other source should be disregarded.

- If there is documentation anywhere in the Only Acceptable Sources that the patient either currently smokes or is an ex-smoker that quit less than one year prior to hospitalization, select “Yes,” regardless of whether or not there is conflicting documentation. In all other cases, “No” should be selected.

### 4. Comfort Measures Only

- Physician documentation of comfort measures has been expanded.

Other resources available to the abstractor include QNet Quest found at <http://www.qnetquest.org/quest/index.do?mode=9c&image>. Abstractors using Quest should regard the answers the same as information provided in the *Specifications Manual*.

Health Services Advisory Group’s Clinical Quality Specialists (CQSs) are also available to assist abstractors. The CQSs may require additional time to re-search the answers they provide to abstraction questions or concerns.

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